		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025619

Facility Name: Shwanee Christian Nursing Center

Address: 1901 North 13th - P O Box 680 (Number) Herrin (City) 62948 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** ( )

HFS ID Number: 37-0841562005

Date of Initial License for Current Owners: 09/01/1980

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William E. Castor **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2004 to June 30, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	159	Skilled (SNF)	159	58,035	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,897	9,157	8,246	43,300	8
9	SNF/PED					9
10	ICF	7,272	2,182		9,454	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,169	11,339	8,246	52,754	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.90%

D. How many bed-hold days during this year were paid by the Department?
698 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 159 and days of care provided 8,246

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	235,690	21,417	13,925	271,032		271,032		271,032			1
2	Food Purchase		222,540		222,540		222,540	(1,756)	220,784			2
3	Housekeeping	225,881	28,659		254,540		254,540		254,540			3
4	Laundry											4
5	Heat and Other Utilities			115,298	115,298		115,298	13,599	128,897			5
6	Maintenance	49,828	33,819	24,868	108,515		108,515	11,581	120,096			6
7	Other (specify):*											7
8	**TOTAL General Services**	511,399	306,435	154,091	971,925		971,925	23,424	995,349			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,964,772	361,244	9,535	2,335,551		2,335,551		2,335,551			10
10a	Therapy			591,538	591,538		591,538		591,538			10a
11	Activities	27,104			27,104		27,104		27,104			11
12	Social Services	111,287	1,287	5,014	117,588		117,588	508	118,096			12
13	CNA Training											13
14	Program Transportation			2,470	2,470		2,470	(2,470)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,103,163	362,531	614,557	3,080,251		3,080,251	(1,962)	3,078,289			16
	C. General Administration											
17	Administrative	77,929	1,364	361,116	440,409		440,409	(284,694)	155,715			17
18	Directors Fees											18
19	Professional Services			25,704	25,704		25,704	13,044	38,748			19
20	Dues, Fees, Subscriptions & Promotions			81,070	81,070		81,070	(34,443)	46,627			20
21	Clerical & General Office Expenses	137,288	7,715	111,495	256,498		256,498	32,913	289,411			21
22	Employee Benefits & Payroll Taxes			581,440	581,440		581,440	37,085	618,525			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,061	13,061		13,061	7,621	20,682			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			145,541	145,541		145,541	1,131	146,672			26
27	Other (specify):*											27
28	**TOTAL General Administration**	215,217	9,079	1,319,427	1,543,723		1,543,723	(227,343)	1,316,380			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,829,779	678,045	2,088,075	5,595,899		5,595,899	(205,881)	5,390,018			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shwanee Christian Nursing Center #0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			195,007	195,007		195,007	31,691	226,698			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			471,054	471,054		471,054	(6,520)	464,534			32
33	Real Estate Taxes			333	333		333		333			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,291	1,291		1,291		1,291			36
37	**TOTAL Ownership**			667,685	667,685		667,685	25,171	692,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			22,475	22,475		22,475		22,475			39
40	Barber and Beauty Shops	20,418	808		21,226		21,226		21,226			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,053	87,053		87,053		87,053			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	20,418	808	109,528	130,754		130,754		130,754			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,850,197	678,853	2,865,288	6,394,338		6,394,338	(180,710)	6,213,628			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,637	30		9
10	Interest and Other Investment Income	(11,819)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,470)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,668)	21		24
25	Fund Raising, Advertising and Promotional	(8,098)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(22,850)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,268)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(79,442)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (79,442)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (180,710)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Shwanee Christian Nursing Center

ID# 0025619

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Exempt Interest Income - Endowment	$ 4,852	32	1
2				2
3	Vending	(1,756)	2	3
4	Activity	508	12	4
5	Marketing	(26,345)	20	5
6	Miscellanous	(109)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,756)	0	0	0	0	0	0	0	0	0	0	(1,756)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	13,599	0	0	0	0	0	0	0	0	0	13,599	5
6	Maintenance	0	11,581	0	0	0	0	0	0	0	0	0	11,581	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,756)	25,180	0	0	0	0	0	0	0	0	0	23,424	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	508	0	0	0	0	0	0	0	0	0	0	508	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,470)	0	0	0	0	0	0	0	0	0	0	(2,470)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,962)	0	0	0	0	0	0	0	0	0	0	(1,962)	16
	C. General Administration													
17	Administrative	0	(284,694)	0	0	0	0	0	0	0	0	0	(284,694)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,044	0	0	0	0	0	0	0	0	0	13,044	19
20	Fees, Subscriptions & Promotions	(34,443)	0	0	0	0	0	0	0	0	0	0	(34,443)	20
21	Clerical & General Office Expenses	(64,777)	97,690	0	0	0	0	0	0	0	0	0	32,913	21
22	Employee Benefits & Payroll Taxes	0	37,085	0	0	0	0	0	0	0	0	0	37,085	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,621	0	0	0	0	0	0	0	0	0	7,621	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,131	0	0	0	0	0	0	0	0	0	1,131	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(99,220)	(128,123)	0	0	0	0	0	0	0	0	0	(227,343)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,938)	(102,943)	0	0	0	0	0	0	0	0	0	(205,881)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Shwanee Christian Nursing Center** **#** **0025619** **Report Period Beginning:** **July 1, 2004** **Ending:** **June 30, 2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,637	23,054	0	0	0	0	0	0	0	0	0	31,691	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,967)	447	0	0	0	0	0	0	0	0	0	(6,520)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,670	23,501	0	0	0	0	0	0	0	0	0	25,171	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,268)	(79,442)	0	0	0	0	0	0	0	0	0	(180,710)	45

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		5	Utilities	$	Christian Homes Inc.		$ 13,599	$ 13,599	1
2	V		6	Maintenance				11,581	11,581	2
3	V		17	Administrative	361,116			76,422	(284,694)	3
4	V		19	Professional Services				13,044	13,044	4
5	V		21	Clerical				97,690	97,690	5
6	V		22	Employee Benefits				37,085	37,085	6
7	V		24	Travel & Seminar				7,621	7,621	7
8	V		26	Insurnace				1,131	1,131	8
9	V		30	Depreciation				23,054	23,054	9
10	V		32	Interest				447	447	10
11	V									11
12	V									12
13	V									13
14	Total				$ 361,116			$ 281,674	$ * (79,442)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: ne 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Herrin		x	Refinance Debt		09/01/93	$ 2,720,000	$ 1,990,000		0.0700	$ 141,925	1
2	1996-A Bonds	x		Refinance Debt		07/01/96	225,000	189,000		0.0700	13,376	2
3	1999-A Bonds	x		Refinance Debt		01/01/99	1,000,000	876,200		0.0700	59,755	3
4	2001-Z Bonds	x		Refinance Debt		10/01/01	3,200,000	3,170,133		0.0700	222,964	4
5												5
	Working Capital											
6												6
7	Chi Revolving Fund	x		Refinance Debt				70,347		0.0200	24,958	7
8	Financing Fee Amortization	x		Refinance Debt							8,076	8
9	TOTAL Facility Related						$ 7,145,000	$ 6,295,680			$ 471,054	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,145,000	$ 6,295,680			$ 471,054	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Shwanee Christian Nursing Center **#** 0025619 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ n/a	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shwanee Christian Nursing Center COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0025619

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	007-000-230 - W1S N75 408-138	$ 332.82	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 332.82	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			9,903	2
3	TOTALS	180,000		$ 81,074	3

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 47,600	$ 3,262	$ 1,101,276	4
5			1980	1980	107,504		20	5,375	5,375		5
6											6
7											7
8	Home Office Allocation				71,684	2,311		2,311		36,013	8
	Improvement Type**										
9	Storage Building			1981	6,510		20			6,510	9
10	Blank										10
11	Hearing & A/C System			1982	37,091		20			37,091	11
12	TV System			1982	9,873		15			9,873	12
13	TV System			1982	1,182		20			1,182	13
14	Building Improvements			1982	159,808	4,098	39	4,098		96,303	14
15	Building Improvements			1983	22,362	588	38	588		13,230	15
16	Blank										16
17	Smoke Alarm			1984	650		20			650	17
18	Building Improvements			1985	44,866	1,122	40	1,122		22,160	18
19	Blank						35				19
20	Windows			1985	39,252	981	40	981		19,375	20
21	Ceiling Tile			1985	4,232	212	20	212		4,152	21
22	A/C System			1985	4,200		10			4,200	22
23	Light Fixtures			1985	777		10			777	23
24	Ceiling Tile			1986	1,874	94	20	94		1,747	24
25	Duct Work			1986	1,600	80	20	80		1,500	25
26	Building Improvements			1986	4,103		10			4,103	26
27	Wiring			1987	891	45	20	45		833	27
28	Dining & Adminstration Wing			1987	688,723	17,218	40	17,218		312,590	28
29	Remodeling			1987	705	35	20	35		627	29
30	Ceiling Duct			1987	510	26	20	26		466	30
31	Duct Work			1987	635	32	20	32		568	31
32	Blank										32
33	Remodeling			1988	552	28	20	28		485	33
34	Electrical Supply			1988	373	19	20	19		329	34
35	Air Cleaner & Duct			1988	1,694		10			1,694	35
36	Mirror			1988	1,562		10			1,562	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HVAC System	1988	$ 4,675	$ 234	20	$ 234	$	$ 4,017	37
38	Windows	1988	705	20	35	20		342	38
39	Baseboard	1988	739	37	20	37		632	39
40	Heat Pumps	1988	27,223	1,361	20	1,361		23,250	40
41	Floor Tile	1988	340		5			340	41
42	Duct Work	1988	22,066	1,103	20	1,103		18,567	42
43	Blank								43
44	Towel & Soap Dispenser	1988	1,976		10			1,976	44
45	Title Policy	1988	3,740	94	40	94		1,582	45
46	Hampton Settlement	1988	74,000	1,850	40	1,850		31,142	46
47	Wall Heat Pump	1989	1,300		10			1,300	47
48	Flourescent Light	1989	673		10			673	48
49	A/C Electrical Work	1989	6,950		8			6,950	49
50	Heat Pumps/Duct System	1989	39,940	1,997	20	1,997		31,952	50
51	Down Spouts	1989	600	7	15	7		600	51
52	Laundry Room Roof	1989	2,200	20	15	20		2,200	52
53	Blank								53
54	Heat Pumps	1989	63,466	3,173	20	3,173		49,182	54
55	Wander Guard	1989	11,417	571	20	571		8,851	55
56	Air Conditioning	1989	5,820		8			5,820	56
57	Ceiling Tile	1989	1,868		10			1,868	57
58	Trimming (1200")	1990	840		5			840	58
59	Remodel Rooms	1990	2,446	122	20	122		1,891	59
60	Baseboard (120')	1990	706		5			706	60
61	Shelving	1990	851		5			851	61
62	Floor Tile	1990	426		5			426	62
63	Water Heater	1990	386	13	15	13		386	63
64	Smoke Detectors	1990	890		5			890	64
65	Flourescent Lights (20)	1990	775		10			775	65
66	Door & Hardware	1990	541		5			541	66
67	Wallpaper	1990	919		5			919	67
68	Relocate Sprinklers	1990	583		10			583	68
69	Brick A/C Holes	1990	1,352	34	40	34		516	69
70	TOTAL (lines 4 thru 69)		$ 3,159,651	$ 81,863		$ 90,500	$ 8,637	$ 1,879,864	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,159,651	$ 81,863		$ 90,500	$ 8,637	$ 1,879,864	1
2	Door Frames	1990	303		5			303	2
3	Paint & Wallpaper	1990	1,118		5			1,118	3
4	Heating Receivers (11)	1990	1,975	116	15	116		1,975	4
5	Kickplates	1990	763		10			763	5
6	Air Conditioner	1990	1,184		8			1,184	6
7	Door Alarm	1990	423		5			423	7
8	Doors & Lock	1990	35,817	1,791	20	1,791		26,716	8
9	Lights (13)	1990	590		10			590	9
10	Door Kickplates (118)	1990	2,104		10			2,104	10
11	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		5,060	11
12	Remodeling	1991	2,733	137	20	137		1,987	12
13	Door Locks	1991	510	26	20	26		377	13
14	Floor Tile Install	1991	10,926		5			10,926	14
15	Cove Base	1991	1,763		10			1,763	15
16	Handrail, Drywall	1991	569		5			569	16
17	Exit Fixtures	1991	1,619		10			1,619	17
18	A/C Units (2)	1991	15,885		10			15,885	18
19	Wallcoverings	1991	483		5			483	19
20	Heat Pump	1991	5,267	351	15	351		4,855	20
21	Walk-in Freezer	1991	8,643	576	15	576		7,968	21
22	Water Heater	1991	867		10			867	22
23	Hall Lights	1992	2,091		10			2,091	23
24	Water Heaters	1992	3,164	211	15	211		2,831	24
25	Heat Pump	1992	653	44	15	44		590	25
26	Heat Pump	1992	7,265	484	15	484		6,332	26
27	4' Loop System	1992	3,723		10			3,723	27
28	Building Lighting	1992	1,142		10			1,142	28
29	Metal Door Frames	1992	840	42	20	42		542	29
30	Garbage Disposals	1994	2,072		5			2,072	30
31	Tub Room Remodel	1993	4,015		10			4,015	31
32	Building Remodeling	1993	6,103	305	20	305		3,675	32
33	Honeywell System	1993	5,031	252	20	252		3,045	33
34	TOTAL (lines 1 thru 33)		$ 3,296,222	$ 86,545		$ 95,182	$ 8,637	$ 1,997,457	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,296,222	$ 86,545		$ 95,182	$ 8,637	$ 1,997,457	1
2	Sink & Doors	1994	3,381		10			3,381	2
3	Blank								3
4	Storage Room Remodel	1994	2,020	101	20	101		1,162	4
5	Sewage Pump System	1994	4,256		10			4,256	5
6	Fire/Garage Door	1994	526		5			526	6
7	Handrails	1995	6,079	509	10	509		6,079	7
8	Remodeling (Side 1)	1995	7,992		5			7,992	8
9	Cabinets	1995	2,343	156	15	156		1,567	9
10	Therapy/Bath	1996	181,372	7,557	24	7,557		69,272	10
11	Fire Alarm System Relay	1996	2,596	260	10	260		2,318	11
12	Cnvt Tub Room/Quiet	1997	1,296		5			1,296	12
13	Water Fountain	1997	502		5			502	13
14	Blank								14
15	Compressor	1997	973		3			973	15
16	Compressor Unit 1516	1997	2,377		3			2,377	16
17	Blank								17
18	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		15,984	18
19	Replace/Rewire Hot Water Heater	1998	9,445	945	10	945		6,930	19
20	Kitchen Heaters	1998	793		3			793	20
21	Compressor/Library #24	1999	2,972		3			2,972	21
22	Keyless locks	1999	1,423		5			1,423	22
23	Wallpaper dining room	1999	3,071		5			3,071	23
24	120 gal water heater	1999	3,000	300	10	300		1,825	24
25	Mixing valve water heater	2000	961	17	5	17		961	25
26	Compressor	2000	1,133		3			1,133	26
27	Security control system	2000	940	94	10	94		533	27
28	Remodel admin office/wiring	2000	1,147	163	5	163		1,147	28
29	Rooftop cond unit	2000	3,373	337	10	337		1,741	29
30	4 ton A/C	2000	2,590	475	5	475		2,590	30
31	4 ton hest pumps	2000	4,780	478	10	478		2,430	31
32	4 Ton Heat Pumps	2000	2,692	269	10	269		1,300	32
33	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		1,050	33
34	TOTAL (lines 1 thru 33)		$ 3,591,347	$ 101,019		$ 109,656	$ 8,637	$ 2,145,041	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,591,347	$ 101,019		$ 109,656	$ 8,637	$ 2,145,041	1
2	Remodel Rooms 9-17	2001	2,657	266	10	266		1,153	2
3	Install Grease Trap	2001	886	177	5	177		752	3
4	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		236	4
5	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		3,129	5
6	Door Control System	1/1/2002	12,860	1,286	10	1,286		4,501	6
7	Countertop-Nursing Station Side 1	1/1/2002	750	50	15	50		175	7
8	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685	921	4	921		3,070	8
9	Install Dishwasher	5/24/2002	1,100	110	10	110		348	9
10	Countertop-Nursing Station Side 2	3/22/2002	760	51	15	51		170	10
11	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		700	11
12	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		681	12
13	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		222	13
14	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		2,625	14
15	Replacement Compressor in kitchen AC	8/31/2002	875	292	3	292		852	15
16	30 Position Nurse Call Station w/d	10/2/2002	1,100	110	10	110		303	16
17	(10) Panic Bars/(41)Door Knobs	12/9/2002	746	149	5	149		385	17
18	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		585	18
19	Remodel DON Office	2/11/2003	871	174	5	174		348	19
20	(12) Wall Signs w/Letters	2/27/2003	789	158	5	158		382	20
21	Nurse Call Light System - Side 1	8/1/2003	970	97	10	97		186	21
22	New Roof - Side 1	8/4/2003	52,263	3,484	15	3,484		6,097	22
23	Roof Replacement	8/4/2003	93,091	31,030	3	31,030		59,474	23
24	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571	114	5	114		200	24
25	Remodel Business Office	2/16/2004	920	184	5	184		261	25
26	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	1,896	10	1,896		2,528	26
27	Service Sink w/double pedal valves	6/3/2004	1,189	119	10	119		129	27
28	Heat Pump	6/16/2004	4,800	480	10	480		520	28
29	Roof Replacement - Resident Rooms	7/30/2004	58,356	3,890	15	3,890		3,890	29
30	Cable for Resident Phone Lines	3/18/2005	1,460	97	5	97		97	30
31	Dining Room Remodeling	3/1/2005	3,493	233	5	233		233	31
32	Resident Rooms Lighting	3/31/2005	1,793	120	5	120		120	32
33	Network Cabling Project	7/1/2004	19,993	1,999	10	1,999		1,999	33
34	TOTAL (lines 1 thru 33)		$ 3,901,632	$ 151,003		$ 159,640	$ 8,637	$ 2,241,392	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,901,632	$ 151,003		$ 159,640	$ 8,637	$ 2,241,392	1
2	Carport	9/22/2000	1,363	136	10	136		657	2
3	Bus barn	3/1/2003	8,752	219	40	219		511	3
4	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	4
5	Parking lot and sewer	2/29/1988	4,658	233	20	233		3,980	5
6	Courtyard walks and projects	9/30/1989	18,906	971	20	971		15,041	6
7	Fencing	6/8/1990	1,700	109	15	109		1,700	7
8	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	916	20	916		14,021	8
9	Drainage, lanscaping & Gazebo	8/14/1991	12,452	622	20	622		8,609	9
10	100' Fence	12/5/1991	1,380	92	15	92		1,250	10
11	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		9,078	11
12	Sidewalk & fence	8/30/1996	3,247	324	10	324		2,054	12
13	Enlarge parking	9/3/2002	2,386	119	20	119		355	13
14	Drainage culvert	3/28/2003	1,419	79	18	79		229	14
15	Dumpster fence	6/24/2003	769	77	10	77		220	15
16	Fully Depreciated Draperies	4/23/1990	7,204		5			7,204	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,802	$ 155,584		$ 164,221	$ 8,637	$ 2,368,738	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 322,230	$ 37,067	$ 37,067	$	Various	$ 182,744	71
72	Current Year Purchases	59,410	4,667	4,667		Various	4,667	72
73	Fully Depreciated Assets	368,902				Various	368,902	73
74	Home Office Allocation	126,877	17,522	17,522			67,595	74
75	TOTALS	$ 877,419	$ 59,256	$ 59,256	$		$ 623,908	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	$ 14,250	$	$	$	8	$ 14,250	76
77	Patient Transportation	New Motor	2000	3,323				3	3,323	77
78										78
79	Home Office Allocation			14,897	3,221	3,221			5,667	79
80	TOTALS			$ 32,470	$ 3,221	$ 3,221	$		$ 23,240	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,051,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 218,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,698	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,637	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,015,886	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 10,800	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 10,800	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Shwanee Christian Nursing Center **#** 0025619 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 368,288	$	1
2	Cash-Patient Deposits	17,723		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,212,360		3
4	Supply Inventory (priced at)	8,919		4
5	Short-Term Investments	1,913		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,006		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,106		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,617,315	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	3,840,064		14
15	Leasehold Improvements, at Historical Cost	141,850		15
16	Equipment, at Historical Cost	775,310		16
17	Accumulated Depreciation (book methods)	(2,921,381)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	219,198		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	17,113		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,154,125	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,771,440	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 206,219	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,723		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,697		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	499		32
33	Accrued Interest Payable	11,608		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Revolving Loan	70,347		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 510,093	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,225,333		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Apt. Income	107,077		43
44		-		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,332,410	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,842,503	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,071,063)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,771,440	$	48

***(See instructions.)**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,359,025)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,359,025)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	572,962	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 572,962	17
	B. Transfers (Itemize):		
18	**Affiliate transfer**	(285,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (285,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,071,063)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,461,299	1
2	Discounts and Allowances for all Levels	(763,036)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,698,263	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,140,070	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,140,070	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,223	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,805	19
20	Radiology and X-Ray	12,156	20
21	Other Medical Services	1,344	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,528	23
	D. Non-Operating Revenue		
24	Contributions	31,351	24
25	Interest and Other Investment Income***	11,819	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,170	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G (L) on Sale of Equipment	1,899	28
28a	Residential/Congregate	4,370	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,269	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,967,300	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	971,925	31
32	Health Care	3,080,251	32
33	General Administration	1,543,723	33
	B. Capital Expense		
34	Ownership	667,685	34
	C. Ancillary Expense		
35	Special Cost Centers	43,701	35
36	Provider Participation Fee	87,053	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,394,338	40
41	**Income before Income Taxes (line 30 minus line 40)****	572,962	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 572,962	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,747	1,798	$ 56,859	$ 31.62	1
2	Assistant Director of Nursing	1,615	1,662	37,402	22.50	2
3	Registered Nurses	11,229	11,556	256,518	22.20	3
4	Licensed Practical Nurses	31,706	32,572	480,300	14.75	4
5	CNAs & Orderlies	112,594	116,453	1,098,389	9.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,282	3,401	35,303	10.38	8
9	Activity Director	1,590	1,620	16,495	10.18	9
10	Activity Assistants	1,095	1,114	10,609	9.52	10
11	Social Service Workers	8,848	9,010	111,287	12.35	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,014	28,796	14.30	13
14	Head Cook	22,862	23,298	206,894	8.88	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,256	4,266	49,828	11.68	17
18	Housekeepers	22,128	22,539	225,881	10.02	18
19	Laundry					19
20	Administrator	1,766	1,811	77,929	43.03	20
21	Assistant Administrator					21
22	Other Administrative	2,289	2,346	55,253	23.55	22
23	Office Manager	1,875	1,922	43,410	22.59	23
24	Clerical	3,881	3,981	38,626	9.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty shop	1,757	1,764	20,418	11.57	33
34	TOTAL (lines 1 - 33)	236,474	243,127	$ 2,850,197 *	$ 11.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	314	$ 13,925	1.3	35
36	Medical Director	120	6,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	1,200	10.3	39
40	Physical Therapy Consultant	4,404	251,147	10A.3	40
41	Occupational Therapy Consultant	4,526	252,643	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,514	88,078	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	88	5,014	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	11,158	$ 618,007		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James E. Burrell	Administrator	0	$ 77,929
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,929

B. Administrative - Other

Description	Amount
Management Expense	$ 361,116
TOTAL (agree to Schedule V, line 17, col. 3)	$ 361,116
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 2,299
Ostrand & Kelly	Legal	6,027
Courtney & Assoc	Regulatory Compl.	4,817
Shank	Consulting	1,113
Townsend & Assoc	Consulting	11,448
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,704

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,945
Unemployment Compensation Insurance	
FICA Taxes	199,368
Employee Health Insurance	264,680
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	18,361
Employee Physicals	1,989
Employee Uniforms	97
TOTAL (agree to Schedule V, line 22, col.8)	$ 618,525

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,180
Advertising: Employee Recruitment	26,355
Health Care Worker Background Check	
(Indicate # of checks performed)	
License	196
Dues	13,026
Subscriptions	1,828
Remote Fees	42
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,627

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,202
Miscellaneous	680
Seminar Expense	3,179
Home Office Allocation	7,621
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,682

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shwanee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shwanee Christian Nursing Center **#** 0025619 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $6,845**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,992** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **87,053**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? None
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Shawnee Christian Nursing Center | kdb
Summary of Payroll Expenses | 6/30/2005 | 3/20/2006

Payroll Tax	Unemploy Contrib	Workers Comp	Health Ins	W.C. Medical Exp	Employee Uniforms	Employee Benefits	Employee Expense	Physicals	Totals	
9,316.09		96,945.00	19,260.00		96.95		18,220.66		143,838.70	
179.55			5,720.00				140.82	1,988.50	8,028.87	
1,016.20			3,320.00						4,336.20	
17,707.58			15,560.00						33,267.58	
18,650.60			27,800.00						46,450.60	
144,195.38			174,180.00						318,375.38	
7,081.65			13,920.00						21,001.65	
1,221.11			4,920.00						6,141.11	581,440.09
199,368.16	0.00	96,945.00	264,680.00	0.00	96.95	0.00	18,361.48	1,988.50	581,440.09	

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